TDI Division of Workers' Compensation
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Medical Fee Dispute Resolution Findings and Decision

General Information

Requester Name
Hand and Wrist Center of Houston

Respondent Name
Mitsui Sumitomo Insurance Company USA

MFDR Tracking Number
M4-26-0281-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
September 29, 2025

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
November 4, 2024	20525	$686.96	$0.00
November 4, 2024	73090	$90.00	$0.00
	Total	$776.95	$0.00

Requester's Position

"Under Texas law, no preauthorization or network participation by me, the medical provider examining and treating the patient, is required when the injured worker is diagnosed with a medical emergency condition(s) such as this patient sustained, and for which I rendered the usual, customary, and necessary treatment(s) indicated by CPT code(s) in my medical record and on the CMS-1500 claim form."

Amount in Dispute: $776.95

Respondent's Position

"The provider should have requested preauthorization for the services that have been disputed. Preauthorization was required however; the provider is claiming that the procedure that he had performed was a medical emergency. The carrier disagrees. We do not believe that the services provided were in response to a medical emergency. The provider's comments concerning the alleged emergency medical treatment are conclusory and fail to explain why the claimant's medical condition constituted a medical emergency. The provider's operative report is part of the attached documents."

Response Submitted by: Flahive, Ogden & Latson

Findings and Decision

Authority

This medical fee dispute is decided according to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation (DWC).

Statutes and Rules

1. 28 Texas Administrative Code (TAC) §133.307 Medical Fee Dispute Resolution.
2. 28 TAC §133.2 Definitions
3. 28 TAC §134.600 Preauthorization, Concurrent Utilization Review, and Voluntary Certification of Health Care.

Denial Reason(s)

The insurance carrier reduced or denied payment for the disputed services with the following claim adjustment code(s):

- 197 – Payment adjusted for absence of precert/preauth
- W3 – Appeal/reconsideration.
- P12 – Workers compensation state fee schedule adjustment.

Issues

1. Did the insurance carrier issue payments after the submission of the medical fee dispute resolution request?
2. Is the requester entitled to reimbursement for the services in dispute?

Findings

1. Flahive, Ogden & Latson, on behalf of Mitsui Sumitomo Insurance Company of America, states in pertinent part:

   "…the provider also billed for an office visit and the issuance of a DWC 73 Work Status Report on November 4, 2024. We are attaching a copy of the provider's CMS-1500 showing a charge of $300. Also attached are documents related to that visit, along with an Explanation of Review (EOR) dated December 4, 2024, which recommended payment of $248.45."

   A review of the MFDR request and the table of disputed services shows that the requester is seeking reimbursement only for CPT codes 20525 and 73090. These services were provided on November 4, 2024, the same date as the office visit billed under CPT codes 99203-57 and 99080-73, which have already been paid by the insurance carrier. The requester is seeking a total reimbursement of $776.95 for the disputed CPT codes 20525 and 73090. Accordingly, these charges are the sole focus of this MFDR review.

2. The dispute involves the denial of payment for a procedure performed in an outpatient facility (place of service code 22) on November 4, 2024. The insurance carrier denied reimbursement for the surgical services, citing that preauthorization was required but not obtained.

According to 28 TAC §134.600(p)(2), non-emergency health care requiring preauthorization includes *"outpatient surgical or ambulatory surgical services as defined in subsection (a) of this section."*

A review of the submitted documentation confirms that preauthorization was not obtained for the surgical services in question. The injured employee was evaluated by the same physician who subsequently decided to perform the surgery. This is reflected by the use of modifier -57 appended to the new patient office visit (CPT 99203), indicating that the evaluation led to the initial decision for surgery.

According to the Novitas Medicare JH Modifier 57 Fact Sheet, modifier -57 is used to identify that an Evaluation and Management (E/M) service resulted in the decision to perform a major surgery, either on the day before or the day of the procedure (with a 90-day global period).

The requester contends that preauthorization was not required because the procedure constituted emergency care, and therefore, the carrier is obligated to provide payment in accordance with the Texas Labor Code (TLC) and Division of Workers' Compensation (DWC) rules.

A review of the submitted documentation finds that the provider did not meet the burden of proof to establish that the surgical services were emergency care. Under 28 TAC §133.307(c)(2)(N), a requester's position statement must include:

1. The reasoning supporting payment of the disputed fees;
2. An explanation of how the Labor Code and DWC rules, including applicable fee guidelines, apply to the dispute; and
3. Documentation supporting the requester's position for each disputed fee issue.

The provider's position statement did not demonstrate how the care rendered on the disputed date of service met the definition of emergency care under 28 TAC §133.2. Furthermore, the medical documentation provided does not support that the treatment was for a medical emergency as defined by rule.

Because the services were not shown to be emergency care, and preauthorization was not obtained as required by 28 TAC §134.600, the requester is not entitled to reimbursement for the disputed surgical services.

Conclusion

The outcome of this medical fee dispute is based on the evidence presented by the requester and the respondent at the time of adjudication. Though all evidence may not have been discussed, it was considered. DWC concludes that the insurance carrier is not liable for the disputed services.

Order

Based on the submitted information, pursuant to Texas Labor Code 413.031, the DWC hereby determines the requester is entitled to $0.00 reimbursement for the services in dispute.

Authorized Signature

		November 21, 2025
Signature	Medical Fee Dispute Resolution Officer	Date

Your Right to Appeal

Either party to this medical fee dispute has a right to seek review of this decision under 28 TAC §133.307, which applies to disputes filed on or after **June 1, 2012**.

A party seeking review must submit DWC Form-045M, *Request to Schedule, Reschedule, or Cancel a Benefit Review Conference to Appeal a Medical Fee Dispute Decision (BRC-MFD)* and follow the instructions on the form. You can find the form at www.tdi.texas.gov/forms/form20numeric.html. DWC must receive the request within **20 days** of when you receive this decision. You may fax, mail, or personally deliver your request to DWC using the contact information on the form or the field office handling the claim. If you have questions about DWC Form-045M, please call CompConnection at 1-800-252- 7031, Option three, or email CompConnection@tdi.texas.gov.

The party seeking review of the MFDR decision must deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with DWC. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** with any other required information listed in 28 TAC §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.